SCOPE OF SERVICES

Background

The County employs approximately 28,000 individuals in South Florida, although the Employee Group Dental Insurance Program (Program) covers 40,000 lives. Covered groups include employees, retirees (Medicare and Non-Medicare eligible) and their eligible dependents of Miami-Dade County, the Industrial Development Authority, Housing Finance Authority, as well as, approximately 60 judges (refer to the census data provided in **Attachment 1, Census**). Jackson Health System (JHS) had been a covered group within the County's Program since the inception of the current agreements. However, JHS will not participate as a covered group in the County's future Program at this time. Modifications to the County's benefit levels are subject to collective bargaining agreements. Additionally, the County reserves the right, at its sole discretion, to alter the current Plan Design going forward.

The County's existing Plan Design includes two (2) Dental Health Maintenance Organization (DHMO) **and** one (1) Dental Preferred Provider Organization (DPPO) options, as follows:

Contractor	**Plan Design Options**
Delta Dental Insurance Company	DPPO) Indemnity
Metropolitan Life Insurance Company/SafeGuard	DHMO (Pre-paid)
Humana Dental/Oral Health Services (OHS)	DHMO (Pre-paid)

Each dental plan provides a choice of two benefit tiers: standard and enriched. The Delta Dental (PPO) Plan includes a preferred network of dentists who, if selected for services, offer Members reduced out-of-pocket expenses. All dental plan options are fully insured. Design options and corresponding benefits are available for review at the County's Benefits Webpage. Please refer to the following link: http://www.miamidade.gov/humanresources/health.asp for further information. Proposer may also refer to the summary of benefits provided in **Attachment 2, Summary of Benefits Coverage Handbook**, for further information on existing Program plan summaries descriptions.

Note: The International Association of Firefighters Local 1403 ("IAFF") offers a Union-sponsored DHMO and DPPO options to its Members. IAFF Members will continue to be offered the opportunity to select from the County's plan design options, or if eligible, one of the plan options offered through IAFF. Please refer to the Miami-Dade County Employee Group Dental Insurance Program enrollment figures provided in **Attachment 1, Census** to identify all active participants, including participants within the Fire Union sponsored dental plans. The County reserves the right at any time during the term of any agreement resulting from this Solicitation; to allow either the JHS and/or the IAFF group the option to participate in the Program.

Additionally, County anticipates continuing with the existing contribution strategy, per employee, per pay-period. The County currently contributes 100% of the single employee plan cost for the standard benefit. The employee pays the full cost for dependent coverage and if selected, the incremental cost for the enriched benefit option. The rate structure is as follows: 1) employee only; 2) employee plus one dependent; and 3) employee plus two or more dependents. The County contribution levels are subject to change, primarily based on collective bargaining agreements, at the County's sole discretion. The County plans to remain fully-insured for its dental benefits for the foreseeable future.

Objective

The objective of this Solicitation is to verify competitiveness of the County's current Program and ultimately to establish contracts for the delivery of a comprehensive Employee Group Dental Insurance Program with the most competitive rates in the marketplace, professional plan administration and the flexibility and accessibility for the actively employed and retired populations to choose the dental plan that fits their needs from one or more qualified providers who provide employees with quality dental care at affordable prices to help cover the cost of dental care, ranging from basic preventative coverage to major dental work.

Proposer's proposed Program should match, to the utmost extent possible, or improve the County's existing Plan design by expanding features for possible consideration and inclusion in the County's Program, at the County's sole discretion (e.g., Rollover, Preventive Care Waiver, etc.). Please refer to Section 2.7 and the Proposer Information document for further information.

Qualification Requirements

A. Minimum Qualification Requirements
The Proposer shall:

1. Be licensed by the State of Florida, to transact the appropriate insurance product and services for which the proposal is being submitted for, as of the proposal due date.

2. Be financially stable to render the services listed herein, as of proposal due date. To satisfy this requirement, Proposer shall have a minimum "A-" rating from A.M. Best Company, and no less than a Financial Classification of "VII" or higher as of the firm's most recent rating. If Proposer's rating does not meet the aforementioned rating requirement, the Proposer shall provide to the County: 1) its most recent **independently audited** financial statements with the auditor's notes for each of its past two (2) fiscal years.

(Note: This is a continuing requirement throughout contract award and term of the agreement.)

B. Preferred Qualifications
The Proposer should:

1. Confirm that Miami-Dade County's account will not increase the Proposer's nationwide current book of business by more than 25%.

2. Have a minimum of five (5) years of experience in the State of Florida administering claims and providing similar services to those listed in this Solicitation, for governmental groups of 10,000 employees or greater. This preferred qualification is also applicable to the Proposer's subcontractors.

3. Have sufficient and qualified dental provider networks within the areas in which County employees and retirees reside (primarily in South Florida). Retirees and out-of-area dependents should have sufficient access to providers and should be covered based on the same plan designs as in-area participants. The minimum access standards are listed in Section 2.4, (8) (b).

This document is a draft Scope of Services for a future solicitation and is subject to change without notice. This is not an advertisement.

General Information and Specifications

1. Any full-time County employee who has completed 60 days of employment is eligible for coverage, or as determined by the County. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 60 continuous days of employment is eligible for coverage. If an election is made, coverage is effective the first day of the month following completion of the eligibility period without any actively-at-work exclusion.

2. Dependent eligibility is defined as follows:

Eligible Dependents	
Spouse*	Subscriber's legal spouse
Domestic Partner (DP)*	Subscriber's Domestic Partner in accordance with County Ordinance 08-61.
Child	Subscriber's biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.
Child with a Disability	Subscriber's Dependent child incapable of sustaining employment because of a mental or physical disability may continue coverage beyond the limiting age, if enrolled for dental prior to age 25. Proof of disability must be submitted to the Plan on an ongoing basis.
Step Child	Subscriber's spouse's child, as long as the Subscriber remains legally married to the child's parent. Subscriber's domestic partner's child, as long as the domestic partnership continues to meet the requirements of Miami Dade County Ordinance No. 08-61, Sec. 11a-72.
Foster Child	A child that has been placed in Subscriber's home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible until their age of maturity.
Legal Guardianship	A child (ward of Subscriber) for whom Subscriber has legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Subscriber's ward may be eligible until their age of maturity.
Grandchild	A newborn dependent of Subscriber's covered child; coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered. After 18 months, the grandchild must have met the criteria of permanent legal ward of the Subscriber.

Coverage Limiting Age for Dependent Children - Your dependent child's coverage ends on:

Dental - December 31 of the calendar year child turns 25. There is no extension for dental coverage unless the adult child is disabled. For Plan Year 2016, at its sole discretion, the County may elect to extend coverage for dental until the end of calendar year the child turns 26.

***Subscriber's Spouse or Domestic Partner** (DP) is **not** an eligible dependent for coverage if also a County employee. Eligible employees are not permitted to cover each other on their group medical/dental plans. Ex-spouses may not be enrolled for group benefits under any circumstance, even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex-spouse.

3. **Attachment 1**, **Census** further identifies all active employees that are eligible for union sponsored dental options.

4. Retiring employees should be provided a one-time opportunity, at the time of retirement (no later than 30 days from the retirement date), to change their dental insurance plan election in order to allow participation in the benefit option which best meets their retirement needs. The selected Proposer should allow a separate annual enrollment change period for retirees, as requested by the County.

5. All provisions should conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), where applicable. Please refer to the **HIPAA Business Associate Agreement (BAA)** included in the County's Form of Agreement herein provided as **Appendix C**. The selected Proposer is required to execute a BAA with the County as part of any award issued, resulting from this Solicitation.

    a) New employees and their eligible dependents are eligible for coverage without proof of insurability.

    b) Employees who do not enroll within their initial benefits eligibility period, and do not satisfy a HIPAA special enrollment qualifying event, may not enroll until the following annual open enrollment period with a January 1 effective date.

    c) All employees and dependents enrolled as of December 31, 2015 are eligible for coverage with no actively-at-work exclusion.

6. The following rules apply for adding dependents:

    a) New Dependents - A dependent of an insured may be added to the Program by submitting an application within 45 days (60 days for newborns) of acquiring the dependent status. The employee must enroll the dependent within 45 days after the marriage, registration of Domestic Partnership or birth/adoption of a child (60 days for newborns). Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn and children placed for adoption is effective as of the date of birth, or the earlier of 1) placement for adoption, or 2) adoption date. The change in rate, if applicable, is effective the first day of the month following the birth or the earlier of 1) placement for adoption or, 2) adoption date.

    b) If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 45 days after the other coverage ends.

c) Change in Status (CIS) - A dependent may be added to, or deleted from, the Program at any time during the year, under HIPAA special enrollment, or pursuant to IRS Section 125 provisions, as adopted by the County. Proof of the change in status must be submitted at the time of request for change. Please refer to item 6(a) above for information on adding a new dependent. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the Change in Status (CIS) Form is received by the County within the first 31 days from birth, the rate is waived for the first 31 days. If the CIS Form is received after the first 31 days, but within 60 days of the birth, the new rate will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The rate is waived for the first 31 days if the CIS Form is received by the County within the first 31 days from the earlier of: a) adoption, or b) placement for adoption. If the CIS Form is received after the first 31 days, but within 60 days of the event, the new rate will be charged retroactive to the earlier of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the County.

7. Employee membership terminates on the last day of the pay period the employee ceases active work, for any reason other than an approved leave of absence or retirement, and for which applicable payroll deductions (or direct payment, if on a leave of absence) are made.

8. The selected Proposer should:

   a) Adhere to established standards for the consideration and credentialing of providers in its networks.

   b) Perform a Geo Access analysis on an annual basis and make reasonable efforts to contract with additional providers, where minimum access standards may not be met. The minimum access standards are one (1) provider within 5 miles, or two (2) providers within 10 miles.

   c) Pursue necessary actions to discourage provider disparagement of the County's Employee Group Dental Insurance Program.

   d) Notify the County of any change in its financial ratings by A.M. Best, or any significant change to selected Proposer's financial position and/or credit rating. Notification of such change should be provided to the County's Project Manager, no later than three (3) business days after the selected Proposer has been apprised of such change. Notification to the County should include the submission of the selected Proposer's most recent independently audited financial statements for each of its past two (2) fiscal years, **or** the U.S. Securities and Exchange Commission's (SEC) Annual 10-K Report for its past two (2) years.

   Note: After proposal submittal, the County reserves the right to require additional information from Proposers (or subcontractors) to determine financial capability (including, but not limited to, annual reviewed/audited statements with the auditor's notes for each of the past two (2) complete fiscal years).

9. Contract is to be issued in the State of Florida unless selected Proposer obtains permission from the County to use an alternative situs.

Enrollment/Communication Provisions

The selected Proposer should:

1. Provide promotional and enrollment materials at a minimum of thirty (30) days prior to the start of the County's annual open enrollment period, anticipated to be late October/early November for each upcoming Plan Year. Enrollment materials should be provided in printed format, in an adequate amount (for approximately 10,000 employees at the County's discretion. The County may also require the selected Proposer to provide enrollment materials in alternate formats (i.e., Braille, different languages, large print and/or audio compact disk). An electronic version of enrollment materials, as well as a customized benefits website should be made available to all eligible employees/retirees during Annual ~~initial~~ enrollments and to new enrollees. Materials include, but are not limited to, the Certificate of Coverage and other materials, as deemed necessary by the County. The costs of printing and producing materials, in all formats, are the sole responsibility of the selected Proposer.

2. Print, mail and electronically produce the Certificate of Coverage directly to Members' homes at least thirty (30) days prior to the start of the Plan Year, effective January 1st, at no additional cost to the County. The selected Proposer should provide additional supplies of the Certificate of Coverage to the County, as required by the County.

3. Utilize authorized County-specific forms and materials, as deemed necessary by the County.

4. Mail identification (ID) card to each enrolled Member within 5 business days from the date of receipt of each eligibility tape, excluding weekends and holidays. On-demand temporary ID card printing should be available at the selected Proposer's website, wherein Members can easily print temporary ID cards, when any of the following events occur:

    a) Change in coverage option;
    b) Change in coverage tier; and/or
    c) A replacement/duplicate card is requested.

5. Ensure that Members/Subscribers can be identified by social security number, employee ID number ***and*** bargaining unit, as required by the County. The selected Proposer should ensure that all Social Security Numbers are maintained for all Members/Subscriber enrolled in the Program, and as such, should bear the responsibility of protecting the privacy and legal rights of all Members/Subscribers.

6. Distribute all communication materials to the various County locations no later than two (2) weeks prior to the start of the County's annual open enrollment period. The County should approve in writing all booklets and any/all other employee communications prior to its printing. Additionally, the County retains the right to prohibit distribution of any materials that make false or misleading statements, reference any Program other than the selected Proposer's Program, or any other materials or "giveaways", at the County's sole discretion, which the County deems to be inappropriate.

7. Review its Program-specific information to be included in the County's Employee Benefits Handbook for accuracy and provide the necessary updates to the County no later than September 1st, for each upcoming Plan Year. The County will finalize and publish the Benefits Handbook. The County should retain final approval authority over all communication material.

8. Consent to the use of the County's existing Enrollment Form and/or on-line enrollment process. The Enrollment and Change in Status Forms can be found at the County's benefits website. The County uses web enrollment for the annual open enrollment and anticipates its continued use for ongoing enrollments.

9. Have access to County employees on County premises, as determined by the County.

10. Provide sufficient personnel to attend all initiating annual open enrollment period meetings with the County's Project Manager, and subsequent annual open enrollment period meetings (estimated to be approximately 30 on-site meetings), at the County's sole discretion. Such meetings schedule will be set by the County. The selected Proposer's personnel (i.e., Account Executive/Manager/Representative, etc.) should be available to attend periodic meetings throughout the Plan Year, scheduled by the County, with reasonable notice given.

11. Consent to receiving eligibility data, in an electronic format, in the file layout used by the County.

12. Update eligibility data within one (1) business day from the receipt of such data. The selected Proposer should notify the County of any issues arising within one (1) business day from the time of the data upload.

13. Provide a single point of contact for the purpose of facilitating eligibility and enrollment information, and coordinating any internal distribution of such information, as well as facilitating any necessary transfer of data to third party administrators.

Administrative and Related Services

The selected Proposer should:

1. Implement the County's Employee Group Dental Insurance Program in a timely manner for a January 1, 2017 plan effective date, with enrollment scheduled for October/November of 2016, as deemed necessary by the County.

2. Consent to the County's self-billing process as all benefit plans should be administered on a self-billing fee/premium rate remittance basis.

3. Consent to bi-weekly bank wire-transfers of fee/premium payments, which will be remitted for the prior pay period. The selected Proposer should grant a 30 day grace period for active and leave of absence status employees. Proposer shall not terminate coverage for any member without notification from the County.

4. Pursue Coordination of Benefits (COB) before payment of claims to provide Subscriber/Member with as much coverage as possible while at the same time eliminating over insurance.

5. Administer procedures appropriately to carefully monitor and report the status of dependent children and dependent children of Domestic Partner to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children and dependent children of Domestic Partner losing group coverage due to age or loss of

dependent status should be notified of their COBRA rights. The selected Proposer should notify the County within 60 days after the open enrollment effective date (January 1st of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.

6. Provide all COBRA administration, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums.

7. Verify dependent eligibility at initial enrollment and dependents with different last names at subsequent open enrollments, and notify the County within 60 days of any discrepancies in eligibility. The selected Proposer should verify eligibility for new hires and new enrollees within 30 days and notify the County of any discrepancies in eligibility

8. Provide a local account representative (who should be physically located in the Tri-County area, and be approved by the County) with full account management capabilities. The account representative should assist the County in the administration of the Program approved by the County, in providing all necessary and related services for employees, in obtaining the appropriate resolution of issues including claims problems, and in any other way requested, related to the Services stated herein.

9. Ensure that selected Proposer's Account Executive/Manager and account management team should:

    a) Devote the necessary time to manage the account and be responsive to County needs pertaining to this Scope of Services (this includes being available for frequent telephone calls and on-site consultations with the County staff located in Miami, FL.);
    b) Provide the County with mobile phone numbers and email addresses of all key account management personnel;
    c) Be thoroughly familiar with all of the proposing company's functions that relate to the County's account; and,
    d) Act on behalf of the County to effectively advance County action items through the selected Proposer's corporate approval structure.

10. Comply with the Performance Guarantee Standard Provisions (see **Attachment X, Performance Guarantee Standard Provisions,** which provides an outline of the current standards). Compliance with Performance Guarantee Standard should be measured annually at the end of each Plan Year and any non-compliance within each category should be assessed the amount at risk penalty, payable to the County.

11. Ensure the Program complies with Federal guidelines for Cafeteria Plans pursuant to Internal Revenue Code Section (IRS) 125, as adopted by the County, the Patient Protection and Affordable Care Act (PPACA), the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), and COBRA, as well as all, other applicable federal requirements and all Florida-mandated benefits.

12. Provide Quarterly and Annual Premium vs. Paid Claims Activity Reports within 30 days of the close of the Quarter\Plan Year. Reports should be segregated by active employees, retirees, bargaining unit and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees). The County may require ad-hoc, as deemed necessary, at the County's sole discretion. Such

ad-hoc reports should be provided within 10 days of the County's request.

13. Provide, within 30 days of the effective date of coverage, every new Member with a detailed explanation of the grievance procedures, if not included in the certificate of coverage. Such notification should be provided to Members by mail.

14. If the contract is terminated at any time during the contract period, selected Proposer should transfer to Miami-Dade County all data and records necessary to administer the dental plan in the format and media requested by the County within 15 days of termination date. Selected Proposer should pay claims for all covered members/participants who incurred dental services under contract prior to the termination date.

15. Assume financial responsibility for overpayments due to selected Proposer's errors and fully reimburse the County of such overpayment.

16. Establish and maintain necessary resources to promptly answer all telephone and written inquiries from members regarding any aspect of the dental plan.

17. Maintain and facilitate on-line claims history for participants/members and Miami-Dade County for a period of no less than three years.

Below Section is for informational purposes and will not be utilized for scoring purposes.

Additional Services Design(s)

As the County evolves its benefits strategy, the selected Proposer should be able to adapt to any future changes to the Program that will achieve efficiencies and cost savings to the County, such as the design and creation of Additional Plan Design(s). Proposers are encouraged to submit information for an Additional Plan Design(s) as part of their proposal for consideration. The Additional Plan Design(s) should target cost savings for the County and its employees through a viable approach to additional plan designs and cafeteria type of plan. Proposers providing Additional Plan Design(s) should consider the following criteria:

1. The plan designs should be outlined including plan summary for each benefit level. All state-mandated benefits must be covered and all exclusions, limitations and non-covered items should be fully described.

2. The network should have sufficient providers, to include all specialty levels.

3. Description of how cost savings can be achieved within the Additional Plan Design(s), including assumed enrollment within each offering.

The County will determine whether it is in its best interest to incorporate such additional plan design(s) at the time of negotiation or in the future. In making such determination, the County will consider, among other things, whether savings for the referenced items can be achieved.